STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-11988 QHP
Case No. [redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, following the Appellant's request for a hearing.

After due notice, a hearing was held [redacted] The Appellant represented herself at hearing.

[redacted] was represented by attorney [redacted]. [redacted] for [redacted], was present and provided testimony.

ISSUE

Did the Plan properly deny the Appellant's request for an MRI?

FINDINGS OF FACT

Based upon the competent, material and substantial evidence presented, the Administrative Law Judge finds as material fact:

1. The Appellant is a [redacted] Medicaid beneficiary. (uncontested)
2. The Appellant's physician requested prior authorization for an MRI on [redacted]. (uncontested)
3. The [redacted] reviewed the request for prior authorization.

4. The Medical Director determined the request for prior authorization lacked some of the clinical documentation necessary for the plan to make an approval. (uncontested)

5. The request for prior approval contained an incorrect procedure code, prompting request for clarification/correction by [redacted] staff. Additionally, a request was made for the results of the previous MRI, dating back to [redacted]. (uncontested)

6. The Appellant's physician did not respond to the request for additional clinical information, MRI results and clarification of the code written on the initial request. (uncontested)

7. [redacted] made additional request for the information sought on [redacted], without a response from the Appellant's provider. (uncontested)

8. Following the provider's failure to provide the information sought, [redacted] denied the request for prior authorization.

9. The Appellant appealed the denial on or about [redacted].

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

On May 30, 1997, the Department received approval from the Health Care Financing Administration, U.S. Department of Health and Human Services, allowing Michigan to restrict Medicaid beneficiaries' choice to obtain medical services only from specified Medicaid Health Plans.

The Respondent is one of those Medicaid Health Plans.

> The covered services that the Contractor has available for enrollees must include, at a minimum, the covered services listed below (List omitted by Administrative Law Judge). **The Contractor may limit services to those which are medically necessary and appropriate, and which conform to professionally accepted standards of care. Contractors must operate consistent with all applicable Medicaid provider manuals and publications for coverages and limitations.** If new services are added to the Michigan Medicaid Program, or if services are expanded, eliminated, or otherwise changed, the Contractor must implement the changes consistent with State direction in accordance with the

provisions of Contract Section 1-Z. (Bold emphasis added).

Article II-G, Scope of Comprehensive Benefit Package. MDCH contract (Contract) with the Medicaid Health Plans, September 30, 2004, Page 30.

As it says in the above Department - MHP contract language, a MHP such as [redacted] may limit services to those that are medically necessary and that are consistent with applicable Medicaid Provider Manuals. It may require prior authorization for certain procedures. The process must be consistent with the Medicaid Provider Manual. The pertinent sections of the Medicaid Provider Manual criteria for prior authorization and Medical Necessity are below:

1.10 PRIOR AUTHORIZATION
Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA on the procedure code databases on the MDCH website;
- Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.); and
- Referrals for elective services by out-of-state nonenrolled providers.

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1.5 MEDICAL NECESSITY
Services are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

A service is determined to be medically necessary if prescribed by a physician and it is:

- Within applicable federal and state laws, rules, regulations, and MDCH promulgated policies.
- Medically appropriate and necessary to treat a specific medical diagnosis or medical condition, or functional need.
- Within accepted medical standards; practice guidelines related to type, frequency, and duration of treatment; and within scope of current medical practice.
- Inappropriate to use a nonmedical item.
- The most cost effective treatment available.

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The MHP stated the denial was based upon lack of necessary information in order to determine whether the MRI is medically necessary. It was not asserted it is not medically necessary, rather, that insufficient information was provided for them to determine the medical necessity of the procedure requested. Additionally, it was pointed out that the code for a procedure different than an MRI was used on the request for prior authorization. Despite requests for clarification or correction, none was provided by the Appellant's medical provider.

The Appellant provided testimony concerning her constant pain and worsening symptoms. She asserts her earlier MRI revealed she has degenerative joint disease. She did not address the concerns presented in the MHP's case, specifically, that they did not receive the documentation requested from the Appellant's provider. She otherwise offered no legal challenge to the assertion that the procedure could not be approved due to lack of needed clinical information necessary to make the determination of whether it is medically necessary for the Appellant to have another MRI at this time. She did not address her provider's failure to respond to the Health Plan's requests for additional information.

DECISION AND ORDER

Based on the above findings of fact and conclusions of law, I find the Department's denial of coverage for an MRI in accord with the applicable portion of the Medicaid Provider Manual.

IT IS THEREFORE ORDERED that:

[redacted]
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The Department's decision is UPHELD.

Jennifer Isiogu
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/9/2010

***** NOTICE *****

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 60 days of the mailing date of the Decision and Order or, if a timely request for rehearing was made, within 60 days of the mailing date of the rehearing decision.